PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2013-D16

PROVIDER –
BB&L 95-03 IME Research FTE Group
Seattle, Washington

Provider Nos.: Various –
See Appendix I

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING –
October 4, 2011

Cost Reporting Periods Ended –
Various – See Appendix I

CASE NO.: 05-1479G

INDEX

ISSUE:

Whether time spent in research when the residents were assigned to the inpatient prospective payment system portion and/or the outpatient department of the Providers should be included in the full-time equivalent counts ("FTE") for indirect medical education ("IME") payment in the Providers' IME FTE Count Cost Reports pursuant to 42 C.F.R. § 412.105 (1999).[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services. The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS," formerly the Health Care Financing Administration ("HCFA")) is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulations, and interpretive guidelines published by CMS.[3]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant period and the portion of those costs to be allocated to the Medicare program.[4] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[6]

Since the inception of the Medicare program, Congress has authorized payment to hospitals for the reasonable cost of certain medical education activities such as the training physicians,[7] and these costs were recognized as Medicare allowable costs implicitly included in the definition of costs related to patient care.[8] The Medicare payment for the training of physicians became known as the Direct Graduate Medical Education ("DGME") payment.

As part of the Social Security Amendments of 1983,[9] Congress established the prospective

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[1] *See* Intermediary Exhibit I-2 at ¶ 9 (Stipulation of Facts (March 28, 2011)).
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[4] *See* 42 C.F.R. § 413.20
[5] 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[7] *See* H.R. Rep. No. 89-213, at 32 (1965); S. Rep. No. 89-404, pt. 1, at 36 (1965). *See also* 31 Fed. Reg. 14808, 14814 (Nov. 22, 1966) (promulgating 20 C.F.R. § 405.421 entitled "Cost of educational activities").
[8] *See* 50 Fed. Reg. 27722 (July 5, 1985); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9202, 100 Stat. 82, 171-177 (1986); H.R. Rep. No. 99-453, at 481-483 (1985).
[9] Pub. L. No. 98-21, 97 Stat. 65 (1983).

payment system for hospital inpatient operations ("IPPS") and specifically excluded DGME from IPPS.[10] As part of this act, Congress also recognized that teaching hospitals incur certain indirect operating costs that would not be reimbursed under either the IPPS or DGME payment methodology. 42 U.S.C. § 1395ww(d)(5)(B) was established to authorize an additional payment known as the Indirect Medical Education ("IME") payment to hospitals with GME programs.[11] The IME payment compensates teaching hospitals for higher-than-average operating costs, which are associated with the presence and intensity of residents' training in an institution but which neither includes nor can be specifically attributed to the cost of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds."[12] Thus, the IME adjustment payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

On March 23, 2010, the Patient Protection and Affordable Care Act of 2010 ("PPACA") was enacted.[13] Specific to the instant case, PPACA § 5505 revised the rules for counting resident time for didactic and scholarly activities when calculating IME payments. This section states in pertinent part;

> (b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:
>
> "(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.
>
> "(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—
>
> "(aa) is recognized as a subsection (d) hospital;
>
> "(bb) is recognized as a subsection (d) Puerto Rico hospital;
>
> "(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

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[10] Social Security Amendments of 1983 § 601(a)(2) and (e) (where § 602(a)(2) amended 42 U.S.C. § 1395ww(a)(4) and § 602(e) added, in pertinent part, 42 U.S.C. § 1395ww(d)(2)(C)(i) and (d)(5)(B)).

[11] Social Security Amendments of 1983 § 601(e).

[12] 42 U.S.C. § 1395ww(d)(5)(B)(ii).

[13] Pub. L. No. 111-148, 124 Stat.119 (2010). Shortly thereafter, on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010) was enacted to amend certain provisions of PPACA. These two public laws are collectively generally known as the Affordable Care Act ("ACA"). 75 Fed. Reg. 71799, 71807 (Nov. 24, 2010). However, as none of the provisions in HERCA are applicable to this case, all citations will be to PPACA as enacted on March 23, 2010.

> "(dd) is a provider-based hospital outpatient department.
>
> "(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.". .
>
> (c) EFFECTIVE DATES.—
> (1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.
> (2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.
> (3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

In addition, PPACA § 10501(j) amended PPACA § 5505 to clarify the law's application by adding the following new subsection at the end:

> (d) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

CMS promulgated regulations governing the determination of full-time equivalent residents for purposes of IME reimbursement for the cost reporting periods at issue at 42 C.F.R. § 412.105(f).[14] In implementing the statutory provisions under PPACA §§ 5505(b) and 10501(j), the Secretary published a final rule on November 24, 2010 ("November 2010 Final Rule")[15] to revise § 412.105(f) to state, in pertinent part, as follows:

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[14] This regulation was re-designated from 42 C.F.R § 412.105(g) to §412.105(f). *See* 62 Fed. Reg. 45966, 46029 (Aug. 29, 1997).
[15] 75 Fed. Reg. 71799 (Nov. 24, 2010).

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
(i) The resident must be enrolled in an approved teaching program. . . .
(ii) In order to be counted, the resident must be assigned to one of the following areas:
(A) The portion of the hospital subject to the hospital inpatient prospective payment system. . . .
(iii)(A) Full-time equivalent status is based on the total time necessary to fill a residency slot. . . .
(B) The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.
(C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in §413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.[16]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University of Washington Medical Center ("UWMC") and Haborview Medical Center ("HMC") (collectively the "Providers") are teaching hospitals located in Seattle, Washington. UWMC is owned by the University of Washington and operated by the University of Washington School of Medicine. HMC is owned by King County, Washington and managed by the University of Washington School of Medicine. The cost reporting periods being appealed by the Providers fall within the years 1995 to 2003.[17] For these cost reporting periods, the Providers claimed reimbursement for the direct and indirect costs of their graduate training programs.

[16] 42 C.F.R. § 412.105(f) (2011) (as amended by 75 Fed. Reg. at 72142).
[17] During the time at issue, the fiscal year ("FY") for UWMC and HMC each ended on June 30th. UWMC and HMC each appealed the following nine FYs: 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, and 2003.

The relevant intermediary assigned to the Providers ("Intermediary")[18] audited the Providers' cost reports for the fiscal years ("FYs") at issue. The Providers appealed the IME research issue to the Board from the relevant original or revised NPR[19] and requested the establishment of a group appeal pursuant to 42 C.F.R. §§ 405.1837 and 405.1841.[20]

The Intermediary submitted multiple jurisdictional challenges regarding the Providers in the group, to which the Providers responded and the Board issued jurisdictional determinations. The Board issued jurisdictional decisions on 10 of the 18 Providers/FYs that requested to be part of this group appeal. Through these jurisdictional determinations, the Board determined that it lacked jurisdiction over 6 of the 18 Providers/FYs.[21] 12 Providers/FYs therefore met the jurisdictional and appeal filing requirements of 42 C.F.R. §§ 405.1835 to 405.1840.[22]

The Providers was represented by Sanford E. Pitler, Esq., of Bennett Bigelow & Leedom, P.S. The Intermediary was represented by Bernard Talbert, Esq., of the BlueCross BlueShield Association.

STIPULATION OF FACTS:

The Providers and Intermediary executed Stipulation of Facts that stipulated to the following pertinent facts in ¶¶ 9 to 14:

9. All of the IME FTE Research time at issue in the Providers' IME FTE Count Cost Reports was spent by residents as part of their training in programs approved by the Accreditation Council for Graduate Medical Education ("ACGME"), an organization recognized by the IME regulation as an appropriate authority for determining which programs are "approved" for IME payment. 42 C.F.R. § 412.105(f)(1)(i) (1999).

10. All of the residents at issue in this Group Appeal for the Providers' IME FTE Count Cost Reports were assigned to the portion of each Provider subject to the PPS and/or to each Provider's outpatient department, and performed their research in rooms listed on the IME FTE Count Cost Reports as being located in the portion of each Provider subject to PPS and/or of each Provider's outpatient department.

11. The Providers have submitted documentation supporting the additional IME Research FTEs for each of the fiscal years at issue, which the

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[18] Premera Blue Cross served as the Providers' Intermediary until October 1, 2004, at which time Noridian Administrative Services became the Intermediary for the Washington State area.

[19] The Harborview Medical Center appeals for FYs 1996, 1997, 1998, 2000 and 2001 were from revised NPRs as was the University of Washington Medical Center appeal for FY 1995. All other appeals were from original NPRs.

[20] Provider Exhibit P-5.

[21] Appendix II identifies the Providers/FYs to which the Board denied jurisdiction

[22] Appendix I identifies the Providers/FYs to which the Board has jurisdiction and, therefore, remain in the group appeal.

Intermediary has audited. The Providers and the Intermediary agree that the IME Research FTEs at issue for each Provider IME FTE Count Cost Report are as follows:

IME Research FTEs At Issue.

A. The parties stipulate that the IME Research FTEs at issue for HMC are:
   1) FYE 6/30/95 - 2.44 FTEs
   2) FYE 6/30/96 - 2.70 FTEs
   3) FYE 6/30/97 - 7.27 FTEs
   4) FYE 6/30/98 - 4.71 FTEs
   5) FYE 6/30/99 - 3.71 FTEs

B. The parties stipulate that the IME Research FTEs at issue for UWMC are:
   1) FYE 6/30/96 - 4.48 FTEs
   2) FYE 6/30/97 - 3.56 FTEs
   3) FYE 6/30/98 - 1.03 FTEs
   4) FYE 6/30/99 - 1.16 FTEs

12. The parties stipulate that the correct current IME FTE cap based on the FYE 6/30/96 cost report, prior to the addition of any IME FTEs that may result from the instant IME Research FTE appeal, for HMC is 151.66. If the Providers prevail in the instant appeal, the parties stipulate further that HMC's IME FTE cap must be increased to 154.36 following the addition of 2.70 IME FTEs per Paragraph 11.A.2, above.

13. The parties stipulate that the correct current IME FTE cap based on the FYE 6/30/96 cost report, prior to the addition of any IME FTEs that may result from the instant IME Research FTE appeal, for UWMC is 239.87. If the Providers prevail in the instant appeal, the parties stipulate further that UWMC's IME FTE cap must be increased to 244.35 following the addition of 4.48 IME FTEs per Paragraph 11.B.1, above.

14. Subject to all final, unappealable decisions made regarding the Intermediary challenges to the Board's jurisdiction, if the Providers prevail on the merits of the IME Research FTE issue raised herein, the Intermediary and the Providers agree that flow-through adjustments for cost reports included in this Group Appeal will be made in accordance with the cost report instructions and regulations as follows:

   A. The Providers' capital IME payments made pursuant to 42 C.F.R. § 413.130 must be recalculated accordingly.

B. The IME FTE counts and the IME payments must be increased for HMC's FYE 6/30/95 cost report, and the FYE 6/30/96 and FYE 6/30/97 cost reports for both HMC and UWMC, subject to final, unappealable decisions reached regarding Board jurisdiction.

C. Because the new prospective payment IME system applied beginning in the Providers' FYE 6/30/98, the IME FTE caps derived from the Providers' FYE 6/30/96 IME FTE count must be adjusted in the FYE 6/30/98 cost report and in each subsequent cost report included in this Group Appeal for both Providers, subject to final, unappealable decisions reached on Board jurisdiction.

D. The current year IME FTE count beginning with the FYE 6/30/98 cost report and all subsequent cost reports appealed herein must be adjusted to reflect the new IME FTE Cap for each Provider, and the prior and penultimate year IME FTE counts must be adjusted as appropriate to reflect the increase in the IME FTE count and in the IME FTE cap, subject to final, unappealable decisions reached regarding Board jurisdiction.

E. The prior year IME resident-to-bed ratios for all cost reports appealed herein for FYE 6/30/99 through FYE 6/30/03 for UWMC and HMC must be adjusted accordingly, subject to final, unappealable decisions regarding Board jurisdiction.[23]

PARTIES' CONTENTIONS:

The Providers assert that they have satisfied the legal requirements for inclusion of their IME FTE resident counts because the residents at issue were enrolled in approved teaching programs and all the residents were assigned to the IPPS-covered portion or the outpatient department of the Providers.[24] They contend that the Intermediary's disallowance of the research time is contrary to the plain language of the statute and regulations.[25] Specifically, for the cost reporting periods at issue, neither the statute nor the regulation required that residents be involved in usual patient care. In addition, neither even referred to the type of allowable activities that had to be performed in order to be included in the IME FTE count.

The Providers acknowledge that, effective October, 1, 2001, CMS amended 42 C.F.R. § 412.105(f)(1) to add subparagraph (iii)(B) requiring that residents be involved in patient care in order for their time to qualify for IME reimbursement purposes.[26] However, the Providers contend that the amended regulation cannot be lawfully applied to this appeal because the rule

[23] Intermediary Exhibit I-2 at ¶¶ 9-14 (Stipulation of Facts (Mar. 28, 2011)).
[24] Providers Final Position Paper at 11-12; Intermediary Exhibit I-2 at ¶¶ 9-10.
[25] Providers Final Position Paper at 10-16, 21-25.
[26] As amended by 66 Fed. Reg. 39828, 39933-39934 (Aug. 1, 2001).

was not in effect during the cost reporting periods at issue.[27] The Providers also acknowledge that, during the time at issue, the agency's manual instructions at the Provider Reimbursement Manual, Part I, CMS Pub. 15-1 ("PRM 15-1"), § 2405.3(F)(2) precluded from the IME FTE counts those residents "engaged exclusively in research."[28] The Provider contends, however, that none of the residents at issue were "exclusively engaged in research," as evidenced by their rotation schedules and Declarations, all of which describe clinical time for the residents during the periods at issue.

The Providers assert that the federal courts have repeatedly upheld prior Board decisions which found that, prior to October 2001, there is no regulatory requirement that only research time related to patient care activities is allowable in calculating the IME FTE count.[29] The Providers acknowledge that the 2008 First Circuit decision in the *Rhode Island Hospital* case upheld the Secretary's exclusion of IME research time from the FTE count prior to October 2001. However, as discussed by the Seventh Circuit in the *University of Chicago* case, the First Circuit did not have the opportunity to consider the revised statutory provisions under PPACA as PPACA was enacted subsequent to its decision in the *Rhode Island Hospital* case.[30] Specifically, in its 2010 decision for the *University of Chicago* case, the Seventh Circuit found that PPACA § 5505(b)(c) was dispositive and concluded that, for the periods January 1, 1983 through October 1, 2001, the IME FTE count includes time residents spent conducting educational research unrelated to the care of Medicare patients.[31]

The Intermediary responds that, consistent with 42 C.F.R. § 413.90(a), time spent on research, over and above usual patient care, is excluded from the IME FTE count for purposes of Medicare reimbursement.[32] The Intermediary acknowledged that PPACA §5505 does permit the inclusion of resident time spent in non-research didactic and scholarly activities for purposes of IME reimbursement. However, this appeal does not involve non-research didactic activities and instead involves exclusive research unrelated to the care of a particular patient.[33] The Intermediary maintains that the Providers are attempting to retroactively include research time into the IME FTE count even though that time has historically been treated by the Providers as non-allowable time for purposes of Medicare reimbursement.

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[27] Provider Final Position Paper at 14-15.
[28] *Id.* at 15.
[29] Provider Group's Supplemental Position Paper at 19-27. *See, e.g., Henry Ford Health Sys. v. Sebelius*, 680 F. Supp. 2d 799 (E.D. Mich. 2009), *rev'd in part and remanded*, 654 F.3d 660 (6th Cir. 2011), *cert. denied*, 133 S. Ct. 73 (2012) ("*Henry Ford* case") (issuance of the 6th Circuit decision occurred after the parties submitted their supplemental position papers); *University of Chicago Med. Ctr. v. Sebelius*, 645 F. Supp. 2d 648 (N.D. Ill. 2009), *aff'd*, 618 F.3d 739 (7th Cir. 2010) ("*University of Chicago* case"); *Rhode Island Hosp. v. Leavitt*, 501 F. Supp. 2d. 283 (D. R.I. 2007), *rev'd*, 548 F.3d 29 (1st Cir. 2008) ("*Rhode Island Hospital* case"); *University Med. Ctr. Corp. v. Leavitt*, 2007 WL 891195 (D. Ariz. Mar. 21, 2007).
[30] Providers Supplemental Position Paper at 26 (citing to *University of Chicago*, 618 F.3d at 744).
[31] *Id.* at 26-27.
[32] Intermediary's Supplemental Position Paper at 5.
[33] *Id.* at 11.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and stipulations, and the evidence contained in the record, finds and concludes that the Intermediary's exclusion of research time from the Provider's IME FTE count was proper.

The Providers contend that, for the fiscal years at issue, neither the IME statute nor the regulation contain the requirement that residents time must involve patient care activities in order to be included in the IME FTE count. The Providers rely on the Seventh Circuit 2010 decision in the *University of Chicago* case, which held that, pursuant to ACA § 5505(b) and effective January 1, 1983, the IME FTE count includes "all the time spent by an intern or resident in an approved medical residency training program in *non-patient care activities, such as didactic conference and seminars* . . . that occurs in the hospital."[34]

The Board disagrees with the Providers. 42 U.S.C. § 1395ww(d)(5)(B)(x)(II), as added by PPACA § 5505(b), permits the Secretary to define the term "non-patient care activities" as a result of the following operative language: "non-patient care activities . . . as such time and activities are defined by the Secretary." Pursuant to this authority, as part of the November 2010 Final Rule, the Secretary promulgated 42 C.F.R. § 412.105(f)(1)(iii)(C) to define that term.[35] A key component of this regulatory definition is the distinction between allowed "non-patient care activities" and non-allowable research time.[36] Specifically, as discussed in the preamble to the November 2010 Final Rule, "research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the 'non-patient care activities, such as didactic conferences and seminars' that are otherwise allowable under sections 5505 of the Affordable Care Act."[37] Pursuant to PPACA §§ 5505(c)(1) and 10501(j), the Secretary applied this regulatory definition retroactively to cost reporting periods beginning on or after January 1, 1983 with the exception of any settled cost reporting periods for which, as of March 23, 2010, there was not a jurisdictionally proper appeal pending on DGME or IME FTE payments.

The Board notes that, the Seventh Circuit's 2010 decision in the *University of Chicago* case did not have the benefit of the revised regulations that were issued as part of the November 2010 Final Rule to implement the PPACA provision. In the *Henry Ford* case,[38] the Sixth Circuit did have the benefit of the November 2010 revised regulations and held that PPACA § 5505 does not specify whether pure research conducted by residents was a reimbursable "non-patient activity" and that this section authorizes the Secretary to define such activities.[39] In particular, the Sixth Circuit upheld the November 2010 implementing regulations which exclude pure research from the definition of reimbursable non-patient care activities, and found that such regulations applied retroactively to January 1, 1983.[40]

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[34] Provider's Supplemental Position Paper at 26 (citing to *University of Chicago*, 618 F.3d at 744 (quoting PPACA § 5505(b) (emphasis in quote)).
[35] *Id.*
[36] 75 Fed. Reg. at 72144.
[37] *Id.*
[38] *Henry Ford Health Sys. v. Department of Health & Human Servs.*, 654 F.3d 660 (6th Cir. 2011).
[39] *Id.* at 666-667.
[40] *Id.* (quoting PPACA § 5505(b)).

The Board agrees the Sixth's Circuit interpretation and application of the statutory and regulatory provisions at issue as described in its decision for the *Henry Ford* case. The Sixth Circuit's decision provides a comprehensive analysis of PPACA § 5505 and the implementing regulations. Additionally, the issue and facts in the *Henry Ford* case are similar to those in the current case, in that both cases involve the FTE counts of residents conducting IME research during the 1990s.

In reviewing the record for the instant case, the Board has found no evidence showing that the research time at issue involved attendance at didactic conferences and seminars. Consequently, the Board finds that the Intermediary's exclusion of research time from the IME FTE count was proper.

The Board notes that, while this finding is not consistent with prior Board decisions involving similar issues,[41] these prior decisions were made prior to the enactment of PPACA and the November 2010 Final Rule implementing the retroactive effect of 42 U.S.C. § 1395ww(d)(5)(B)(x)(II) as added by PPACA § 5505(b). Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all Medicare statutory and regulatory provisions. Consequently, the Board is bound to apply PPACA §§ 5505(b), 5505(c), and 10501(j) and 42 C.F.R. § 412.105(f)(ii)(C), including their retroactive effect, to this case.

DECISION AND ORDER:

The Intermediary's adjustment to exclude research time from the Provider's IME FTE count was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty
Chairperson

DATE: MAY 09 2013

[41] *See, e.g., Univiversity of Chicago Hosps. & Clinics v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2007-D57 (Aug. 8, 2007), *rev'd,* CMS Administrator (Oct. 5, 2007), *rev'd,* 645 F. Supp. 2d. 648 (N.D. Ill. 2009), *aff'd,* 618 F.3d 739 (7th Cir. 2010).

APPENDIX I

	PROVIDERS PENDING IN GROUP APPEAL 05-1479G			
Participant # on SOP	PROVIDER NUMBER	PROVIDER NAME	COST REPORT PERIOD	DATE JURISDICTION ACCEPTED (IF APPLICABLE)
1.	50-0064	Harborview Medical Center	6/30/1995	
4.	50-0008	University of Washington Medical Center	6/30/1996	
6.	50-0008	University of Washington Medical Center	6/30/1997	9/10/2012 (Previously denied jurisdicton on 3/16/2010 and 7/21/10, but reconsidered earlier decisions)
8.	50-0008	University of Washington Medical Center	6/30/1998	9/10/2012 (Previously denied jurisdiction on 3/16/2010 and 7/21/10, but reconsidered earlier decisions)
9.	50-0064	Harborview Medical Center	6/30/1999	
10.	50-0008	University of Washington Medical Center	6/30/1999	05/01/2013 (Previously denied jurisdiction on 2/7/2011 in individual appeal 02-1021, but reconsidered earlier decision)
12.	50-0008	University of Washington Medical Center	6/30/2000	12/17/2010 (granted in individual appeal 03-0687)
14.	50-0008	University of Washington Medical Center	6/30/2001	
15.	50-0064	Harborview Medical	6/30/2002	

		Center		
16.	50-0008	University of Washington Medical Center	6/30/2002	
17.	50-0064	Harborview Medical Center	6/30/2003	
18.	50-0008	University of Washington Medical Center	6/30/2003	

APPENDIX II

	PROVIDERS DISMISSED FROM GROUP APPEAL 05-1479G			
Participant # on SOP	PROVIDER NUMBER	PROVIDER NAME	COST REPORT PERIOD	DATE DISMISSED
2.	50-0008	University of Washington Medical Center	6/30/1995	8/24/2006 (denied in individual appeal 02-1777). Reconsideration denied 8/7/2008.
3.	50-0064	Harborview Medical Center	6/30/1996	9/10/2012
5.	50-0064	Harborview Medical Center	6/30/1997	9/10/2012
7.	50-0064	Harborview Medical Center	6/30/1998	9/10/2012
11.	50-0064	Harborview Medical Center	6/30/2000	9/10/2012
13.	50-0064	Harborview Medical Center	6/30/2001	9/10/2012